

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3754

CERTIFICATE OF DEATH

03743

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Worcester		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin		c. LENGTH OF STAY IN 1b all her life <input checked="" type="checkbox"/> Berlin	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION P. O Box 53		e. STREET ADDRESS P. O Box 53	
3. NAME OF DECEASED (Type or print) Mamie		First A	Middle Bowen
4. DATE OF DEATH 3	Month 13	Day 19	Year 59
5. SEX M	6. COLOR OR RACE AA	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/18/1898
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Doane		14. MOTHER'S MAIDEN NAME Mary ? Doane	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. Howard Bowen, Berlin, Md. Box 53	
17. INFORMANT Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 157X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO 157X (c) DUE TO	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 9 mos.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Chronic cholangitis & cholelithiasis	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-12, 1959, to 3-13, 1959, that I last saw the deceased alive on 3-13, 1959, and that death occurred at 6:25P M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Ivory W. Sully, Jr.</i> M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/18/1959	
22c. NAME OF CEMETERY OR CREMATORIUM Evergreen Cemetery		22d. LOCATION (City, town, or county) (State) Berlin, Md	
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Stewart Funeral Home, Salisbury, Md		24a. REC'D BY REGISTRAR DATE MAR 26 '59	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be relied on by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

СЕМЕЙСТВО ПЕЧАНОВЫХ
ЧИСЛОВЫЕ ПОСЛЕДОВАТЕЛЬНОСТИ

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3755 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

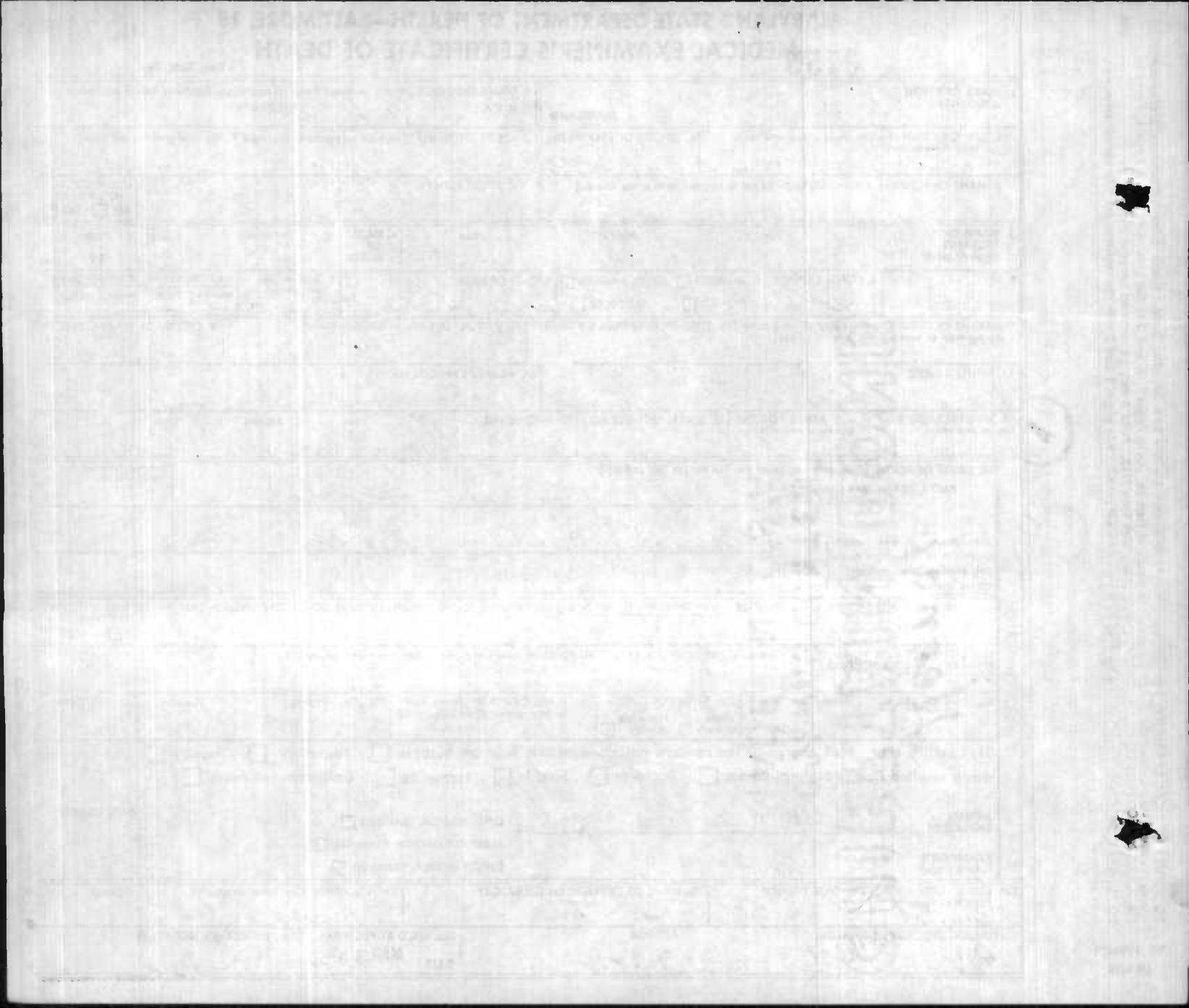
03744

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Worcester MARYLAND		a. STATE	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
Rural Worcester, Md. since 1958		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle
Gerry		W	ayne
4. DATE OF DEATH		Month	Day Year
3		24	1959
5. SEX		6. COLOR OR FACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH
M		C	Dec 19, 1958
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) 7 months yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Baby sitter		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?		Md	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Robert Francis Doughty		Ruth Elizabeth Sartoris	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
(If yes, give war or dates of service)		17. INFORMANT	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
492X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) Pneumonia & probably Upper Respiratory Cold virus	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
19			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE M. E. Sartoris, Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) M. E. Sartoris, Jr.		DATE SIGNED 3/24/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-26-59	
22c. NAME OF CEMETERY OR CREMATORIAL Burton		22d. LOCATION (City, town, or county) Wetzel, Va. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Elgar Wharton - New Church, Va.		24a. REC'D BY REGISTRAR DATE MAR 30 '59	
VS. A15ME(S) 5M 9/55		24b. REGISTRAR'S SIGNATURE C. R. Wharton	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3751

CERTIFICATE OF DEATH

03745

Reg. Dist. No.

1. PLACE OF DEATH

o. COUNTY

Worcester

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Pocomoke City

c. LENGTH OF STAY IN 1b

14 months

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

o. STATE

Maryland

b. COUNTY

Worcester

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

42 Pocomoke City

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

8 Clementine Street

d. STREET ADDRESS

8 Clementine Street

e. IS RESIDENCE ON A FARM?

YES NO

3. NAME OF DECEASED (Type or print)

First
OCAMiddle
ELIZABETHLast
EVANS

4. DATE OF DEATH

Month
MarchDay
4
Year
1959

5. SEX

Female

6. COLOR OR RACE

Colored

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

Feb. 25, 1893

9. AGE (In years last birthday)

66

yrs.

10. IF UNDER 1 YEAR

11. IF UNDER 24 HRS.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housework

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

William E. Wise

14. MOTHER'S MAIDEN NAME

Gracie Collins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

None

17. INFORMANT

Grace Marshall, Pocomoke City, Md.

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

463X

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause lost.

(b)

DUE TO

(c)

Pulmonary Embolism

INTERVAL BETWEEN
ONSET AND DEATH
3 hrs.

Thrombophlebitis of left leg. 10 dgs.

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?
YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19
p. m.20d. INJURY OCCURRED
White Nat white
at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from 27/25/1955 to 31/4/1955, that I last saw the deceased alive on 31/4/1955, 19, and that death occurred at 10:30 AM, from the causes and on the date stated above.

ACTUAL
SIGNATURE

Cecil A. Duverney M.D.

ADDRESS (Street, city or town, state)

DATE SIGNED

PHYSICIAN'S
NAME (Type)

Cecil A. Duverney

801 1/4 St, Pocomoke 3/7/55

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

3-10-59

22c. NAME OF CEMETERY OR CREMATORI

Cool Spring Cemetery

22d. LOCATION (City, town, or county)

(State)

Girdletree, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE

Henry P. Watson Pocomoke City, Md.

ADDRESS

24a. REC'D BY REGISTRAR

DATE MAR 11 '59

24b. REGISTRAR'S SIGNATURE

Arthur S. Krause

STATE OF CALIFORNIA
DEPARTMENT OF MOTOR VEHICLES
CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

113747

3757

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WORCESTER		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN		c. LENGTH OF STAY IN 1b ALL his Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ROUTE #3		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Julia	Middle Ann	4. DATE OF DEATH Month 3 Day 25 Year 1959
5. SEX F	6. COLOR OR RACE AA	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-15-1876
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FRANK Leonard		14. MOTHER'S MAIDEN NAME Atlanta Timmons	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mr. Charles Freeman, Jr. BERLIN, Md. RT 3		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Cerebral thrombosis INTERVAL BETWEEN ONSET AND DEATH 20 hrs	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO Hypertensive Cardiovascular Disease		(c) 5 yrs. former	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Doy, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-29 , 1953, to 3-25 , 1959, that I last saw the deceased alive on 3-25 , 1959, and that death occurred at 5:00 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE Ivory U. Sully, Jr. M.D. ADDRESS (Street, city or town, state) Berlin, Md. DATE SIGNED 3/28/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-28-59	
22c. NAME OF CEMETERY OR CEMINATORY St. Peter's Cemetery		22d. LOCATION (City, town, or county) Newark, Md (State)	
23. FUNERAL DIRECTOR'S SIGNATURE J.F. Stewart Funeral Home, Salisbury, Md		24a. REC'D BY REGISTRAR DATE APR 2 '59	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Straub	

STATE OF PENNSYLVANIA
DEPARTMENT OF LABOR AND INDUSTRY
CERTIFICATE OF OCCUPATION

1952-1953

1953-1954

1954-1955

1955-1956

1956-1957

1957-1958

1958-1959

1959-1960

1960-1961

1961-1962

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03746

3756

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WORCESTER		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN		c. LENGTH OF STAY IN 1b BERLIN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN	
d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First GEORGE	Middle HAROLD	Last GOODMAN
4. DATE OF DEATH			Month MAR. Day 4 Year 1959
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 26, 1883
9. AGE (In years lost birthday) yrs. 75	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER	11. KIND OF BUSINESS OR INDUSTRY CHICKEN PLANT	12. BIRTHPLACE (State or foreign country) ARDMORE, PA
13. FATHER'S NAME GEORGE O. GOODMAN	14. MOTHER'S MAIDEN NAME ANNA SLATER	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no, or unknown) NO	
16. SOCIAL SECURITY NO. 215-18-4091		17. INFORMANT Mrs. G. H. GOODMAN	Address BERLIN, MD
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 434.2 DUE TO acute myocarditis INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Chronic myocarditis (c) Cardiac asthma			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) BERLIN		(County) MARYLAND	
(State) MD			
21. I certify that I attended the deceased from 1-1 , 19 55 , to 3-4 , 19 59 , that I last saw the deceased alive on 3-1-59 , 19 59 , and that death occurred at 7:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Clifford E. Schott		ADDRESS (Street, city or town, state) BERLIN, MD	
PHYSICIAN'S NAME (Type) Clifford E. SCHOTT M.D. BERLIN, MD.		DATE SIGNED 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 3/6/59	22c. NAME OF CEMETERY OR CREMATORIAL EVERGREEN	22d. LOCATION (City, town, or county) BERLIN
23. FUNERAL DIRECTOR'S SIGNATURE Anna A. Burbage		ADDRESS Berlin, MD	
24a. REC'D BY REGISTRAR Arthur S. Flanagan		DATE MAR 9 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Flanagan			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relied on by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03748

3758

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bishop</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Paul Clifford Johnson</u>		4. DATE OF DEATH <u>Mar. 6 1959</u>	Month Day Year
5. SEX <u>Male</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <u>May 5, 1942</u>	9. AGE (In years lost birthday) yrs. <u>16</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>William Jones</u>	14. MOTHER'S MAIDEN NAME <u>Essie Johnson</u>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO.	17. INFORMANT <u>Essie Johnson, Bishop, Md</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>744.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> Congestive heart failure Muscular dystrophy / hypotonia	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>4-5</u> , 19 <u>57</u> , to <u>3-5</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3-5</u> , 19 <u>59</u> , and that death occurred at <u>8:15 A.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>Berlin, Md</u>	
ACTUAL SIGNATURE <u>Ivory V. Sully, Jr.</u>	DATE SIGNED <u>3/6/59</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar. 8, 1959</u>	22c. NAME OF CEMETERY OR CREMATORIAL <u>Evergreen</u>
22d. LOCATION (City, town, or county) <u>Berlin</u>		(State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry J. Watson, Pocomoke City, Md.</u>		24a. ADDRESS <u>—</u>	24b. REC'D BY REGISTRAR DATE <u>MAR 10 '59</u>
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	800	801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	840	841	842	843	844	845	846	847	848	849	850	851	852	853	854	855	856	857	858	859	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	890	891	892	893	894	895	896	897	898	899	900	901	902	903	904	905	906	907	908	909	900	901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 113744

1. PLACE OF DEATH a. COUNTY <i>Worcester</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MD</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Snow Hill</i>		c. LENGTH OF STAY IN 1b <i>61 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address or institution) <i>Snow Hill</i>		e. STREET ADDRESS <i>Church</i>	
3. NAME OF DECEASED (Type or print) <i>Elizabeth</i>		4. DATE OF DEATH Month <i>March</i>	Day Year <i>27 1959</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <i>Nov. 3-1897</i>	8. AGE (In years at birthday) <i>61 1/2</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	11. BIRTHPLACE (State or foreign country) <i>Snow Hill, MD</i>
12. CITIZEN OF WHAT COUNTRY? <i>None</i>		13. FATHER'S NAME <i>Peter J. Jones</i>	
14. MOTHER'S MAIDEN NAME <i>Susie Grany</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>34-32704</i>		17. INFORMANT <i>Mr. William Laws, Snow Hill, MD</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>170X</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		<i>Decreased Auto cravng Pressure</i>	
<i>metastatic Breast Carcinoma</i>		2 years	
<i>Breast carcinoma</i>		5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Jan. 1, 1953</i> to <i>March 27, 1959</i> , that I last saw the deceased alive on <i>March 27, 1959</i> , and that death occurred at <i>11:10 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Robert C. La Mar</i>		ADDRESS (Street, city or town, state) <i>104 Bay St.</i> DATE SIGNED <i>3-28-59</i>	
PHYSICIAN'S NAME (Type) <i>Robert C. La Mar, MD.</i>		22a. BURIAL, CREMATION, DATE THEREOF REMOVAL (Specify) <i>Burial March 30/59</i>	
22b. NAME OF CEMETERY OR CREMATORIAL <i>Bates Methodist Cemetery</i>		22c. LOCATION (City, town, or county) (State) <i>Snow Hill, MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Clayton Dennis</i>		24a. REC'D BY REGISTRAR DATE <i>Arthur S. Thoms MAR 31 '59</i>	
ADDRESS <i>Snow Hill, MD</i>		24b. REGISTRAR'S SIGNATURE	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3752

CERTIFICATE OF DEATH

Reg. Dist. No. 03750

1. PLACE OF DEATH a. COUNTY Worcester		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City		b. COUNTY Worcester			
c. LENGTH OF STAY IN 1b 30 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 209 Sixth Street		d. STREET ADDRESS 209 Sixth Street			
3. NAME OF DECEASED (Type or print) CORA		First M.	Middle LONG		
4. DATE OF DEATH March 4, 1959	Month March	Day 4	Year 1959		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> October 19, 1882	9. AGE (In years lost birthday) 76 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Registered Nurse		10b. KIND OF BUSINESS OR INDUSTRY Nursing	11. BIRTHPLACE (State or foreign country) Pennsylvania	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Irvin Mentzer		14. MOTHER'S MAIDEN NAME Rebecca Slippy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. --	17. INFORMANT None	Address Mrs A. J. Duncan, Pocomoke City, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH Minutes			
443X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		DUE TO (b) Hypertensive Cardiovascular Disease (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1. Cardiac Asthma 2. Generalized Atherosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ADDRESS (Street, city or town, state)			
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Doy 19	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 8, 1957</u> to <u>Mar. 4, 1959</u> , that I last saw the deceased alive on <u>Mar. 4, 1959</u> , and that death occurred at <u>6:45 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED CHARLES W. TRADER, M.D.					
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Charles W. Trader, M.D.		DATE SIGNED 3/5/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-7-59	22c. NAME OF CEMETERY First Baptist	22d. LOCATION (City, town, or county) Pocomoke City, Maryland	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE HENRY S. WATSON		ADDRESS Pocomoke City, Md.	24a. REG'D BY REGISTRAR MAY 5 1959	24b. REGISTRAR'S SIGNATURE ARTHUR S. KIRK	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be relied on by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3760

Items 6,14 Film G239 3-16-59 et

CERTIFICATE OF DEATH

Reg. Dist. No.

103751

1. PLACE OF DEATH a. COUNTY Worcester		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Whaleyville		c. LENGTH OF STAY IN 1b 9 yrs		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Whaleyville		
3. NAME OF DECEASED (Type or print) Veronica Rose Mahoney		4. DATE OF DEATH March 7 1959	5. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX Female	7. COLOR OR RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. DATE OF BIRTH 4/14-1960	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Brooklyn, N.Y.	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Mahoney	14. MOTHER'S MAIDEN NAME Rose	Address Brady		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT Leonard Mahoney - Whaleyville	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute Heart attack</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic myocarditis</u> DUE TO (c)	INTERVAL BETWEEN ONSET AND DEATH 1 week
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3-2-</u> , 19 <u>57</u> , to <u>3-7-</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3-2-</u> , 19 <u>59</u> , and that death occurred at <u>3 A.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>Phas R. Deur</u> M.D. ADDRESS (Street, city or town, state) PHYSICIAN'S NAME (Type)				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/10/59	22c. NAME OF CEMETERY OR CREMATORIAL St. Mary	22d. LOCATION (City, town, or county) Coxsackie N.Y.	
23. FUNERAL DIRECTOR'S SIGNATURE Henry W. Watson	ADDRESS Pocomoke City Md.	24a. REC'D BY REGISTRAR DATE MAR 10 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Thorne	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, file in the funeral director. Page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3761

CERTIFICATE OF DEATH

Reg. Dist. No. 113752

1. PLACE OF DEATH a. COUNTY <i>Worcester</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Worcester</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Stockton</i>		c. LENGTH OF STAY IN 1b <i>1 day</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>None</i>		d. STREET ADDRESS <i>Stockton</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Joe</i>	Middle <i>Louis</i>	Last <i>Mills Jr.</i>
4. DATE OF DEATH	Month <i>March</i>	Day <i>3</i>	Year <i>1959</i>
5. SEX <i>Male</i>	6. COLOR OF RACE <i>Colored</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 2, 1959</i>
9. AGE (In years last birthday) yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	11. BIRTHPLACE (State or foreign country) <i>Stockton, Md.</i>	12. CITIZEN OF WHAT COUNTRY? <i>Stockton, Md.</i>
13. FATHER'S NAME <i>Joe Louis Mills Sr.</i>	14. MOTHER'S MAIDEN NAME <i>Margaret Cope</i>	Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT <i>Mr. Joe Louis Mills Sr., Stockton, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>762.5</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 hrs</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Prematurity</i>			
DUE TO (c)		<i>24 hrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Nat white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>3/2</i> , 19 <i>59</i> , to <i>3/3</i> , 19 <i>59</i> that I last saw the deceased alive on <i>3/2</i> , 19 <i>59</i> , and that death occurred at <i>6 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>John M. Bender M.D.</i>		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <i>John M. Bender M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>March 4, 1959</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Beneficent Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Stockton, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Mayo E. Dennis</i>	ADDRESS <i>Snow Hill, Md.</i>	24a. REC'D BY REGISTRAR DATE <i>MAR 9 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3762

CERTIFICATE OF DEATH

Reg. Dist. No.

103753

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY WORCESTER MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY WORCESTER	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BISHOP		c. LENGTH OF STAY IN 1b LIFE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION _____		d. STREET ADDRESS R.F.D.	
e. IS RESIDENCE ON A FARM YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ELSIE		First ANN	Middle SELBY
4. DATE OF DEATH MARCH 6 1959		Last 79	Month Day Year
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 11, 1880
9. AGE (In years at time of death) 79		10. IF UNDER 1 YEAR yrs. Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JAMES TUBBS	
14. MOTHER'S MAIDEN NAME MARY ANN ZUILLEN		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. ✓		17. INFORMANT DANIEL SELBY BISHOPVILLE, MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0		DUE TO coronary occlusion	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO Arteriosclerotic heart disease	
(c)		myocardial insufficiency	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 9, 1958 , to March 6, 1959 , that I last saw the deceased alive on March 5, 1959 , and that death occurred at M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Mrs. Hazard		ADDRESS (Street, city or town, state) Burgessboro Bee.	
PHYSICIAN'S NAME (Type) Peter Whaley		DATE SIGNED 3-6-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 3/8/59	
22c. NAME OF CEMETERY OR CREMATORIAL St. C. O. P. T.		22d. LOCATION (City, town, or county) (State) Bishopville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Peter Whaley		24a. REC'D BY REGISTRAR DATE MAR 10 '59	
ADDRESS Bishopville, Md.		24b. REGISTRAR'S SIGNATURE Arthur E. Kraus	

CERTIFICATE OF DEATH

for death: Page 4

- 15 -

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03754

CERTIFICATE OF DEATH

Reg. Dist. No.

3753

1. PLACE OF DEATH
a. COUNTY

Worcester

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write
RURAL and give nearest town)

Pocomoke City

c. LENGTH OF STAY IN 1b

life

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

12 Second Street

3. NAME OF
DECEASED
(Type or print)First
MILTONMiddle
L.Last
VEASEY

4. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

April 7, 1877

9. AGE (In years
lost birthday)81
yrs.

10. IF UNDER 1 YEAR

Months
Days

11. IF UNDER 24 HRS.

Hours
Min.10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Lawyer and Banker

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Thomas J. Veasey

14. MOTHER'S MAIDEN NAME

Marietta Richards

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

No.

(If yes, give war or dates of service)

--

16. SOCIAL SECURITY NO.

216-12-1835

17. INFORMANT

Mrs May Y. Veasey, Pocomoke City, Md.

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Ventricular Fibrillation

INTERVAL BETWEEN
ONSET AND DEATH
Minutes

420.0

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause lost.

(b)

DUE TO

(c)

Atherosclerotic heart disease

Years.

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?
YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o. m. 19
p. m.20d. INJURY OCCURRED
While Not while
at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from May 9, 1955, to March 27, 1959, that I last saw the deceased
alive on Mar. 27, 1959, and that death occurred at 640a.m., from the causes and on the date stated above.ACTUAL
SIGNATURE

Charles W. Trader, M.D.

ADDRESS (Street, city or town, state)

DATE SIGNED

PHYSICIAN'S
NAME (Type)

Charles W. Trader, M.D.

302 Market St., Pocomoke, Md. 3-27-59

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

3-29-59

22c. NAME OF CEMETERY

Bethany Methodist

22d. LOCATION (City, town, or county)

(State)

Pocomoke City, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE

Henny S. Watson

ADDRESS

Pocomoke City, Md.

24a. REC'D BY REGISTRAR

DATE MAR 30 '59

24b. REGISTRAR'S SIGNATURE

G. L. 84

31 DEPARTMENT OF STATE - GENEVA
UNITED NATIONS

CRIMINAL COURTS

1972-1973

